THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

Staff Working Paper

October 1988

The Congress of the United States

Congressional Budget Office

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J932-13

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GLOSSARY

CDI	The Catastrophic Drug Insurance program, which will pay (beginning in 1990) part of the costs of prescription drugs for those enrolled under Part B of Medicare.
HI	The Hospital Insurance program, which pays facility and ancillary costs for care provided in hospitals, skilled nursing facilities, hospices, and for home health care for those eligible for benefits under Part A of Medicare.
Part A	The part of the Medicare legislation that authorizes the Hospital Insurance program.
Part B	The part of the Medicare legislation that authorizes the Supplementary Medical Insurance program and the new Catastrophic Drug Insurance program.
SMI	The Supplementary Medical Insurance program, which pays for physicians' services, facility and ancillary costs in hospital outpatient departments and ambulatory surgicenters, and charges by independent laboratories and other medical suppliers for those enrolled under Part B of Medicare.
SNF	Skilled nursing facilities.

SUMMARY

On July 1, 1988, the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) became law. This bill expands Medicare benefits to include outpatient drugs and caps enrollees' copayment costs for other covered services. New benefits will be phased in from 1989 through 1993 and will be financed entirely by enrollees' premiums, part of which will be income-related. This is the first significant expansion of benefits under the Medicare program since its inception in 1966. It represents the largest program expansion since 1973, when eligibility (previously limited to the elderly) was extended to those with permanent disabilities or with chronic renal disease.

New Medicare costs projected under the act will total $30.8 billion over the five-year period from fiscal year 1989 through fiscal year 1993. Once the act is fully implemented, about 22 percent of enrollees will be entitled to higher Medicare benefits in any given year, compared to what they would have received if the act had not been passed. The fully-effective act will increase benefit payments per enrollee by about 7 percent, on average.

All enrollees receive a substantial subsidy under Medicare currently, and a subsidy on total Medicare benefits will remain under the act. That is, enrollees can expect to receive lifetime Medicare benefits that exceed their payroll tax and premium contributions. This is so even for high-income enrollees, who will pay more in new premiums under the act than they can expect to receive in new benefits.

This paper simulates the provisions of the act as if they were fully effective for calendar year 1988. Under the act, Medicare benefits paid per enrollee would be higher by $194, while Medicare premiums payable would be higher by $207. More than 70 percent of enrollees have supplementary "medigap" insurance or receive Medicaid benefits, however, which would alter the impact of the act for them. After adjusting for the effects of medigap insurance and Medicaid, benefits would be $130 higher under the act, on average, while total premium costs would be higher by $114. Enrollees' benefits would increase by less than Medicare's payments because some new Medicare payments would replace current medigap benefits and because benefits would accrue to Medicaid rather than to enrollees for those who are dually eligible. Enrollees' premium costs would increase by less than Medicare premiums payable because medigap premium costs would fall and because Medicaid would pick up both current and new premium costs for poor enrollees.

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INTRODUCTION

In his January 1986 State of the Union address, the President directed the Secretary of Health and Human Services to develop proposals to better protect Americans against catastrophic medical expenses. In November of 1986, the Secretary released a report that addressed three separate aspects of the problem: catastrophic acute-care costs for the Medicare population; long-term care costs for the Medicare population; and catastrophic costs for the nonMedicare population.

The Medicare Catastrophic Coverage Act is the offspring of the Secretary's proposals to deal with the first aspect of the problem, that of acute-care costs for the elderly and disabled. It expands Medicare (and Medicaid) benefits, but maintains the acute-care nature of the Medicare program. The new Medicare benefits enacted by the Congress are considerably greater than the expansion proposed by the Secretary, however--a 7 percent increase when fully implemented, instead of 3 percent. Higher benefits result primarily from a lower cap on copayment costs and from the addition of coverage for prescription drug costs.

The act conforms to the Secretary's original proposal in that the costs of the new Medicare benefits are to be financed entirely by Medicare enrollees. Under the original proposal, costs would have been financed by additional fixed monthly premiums paid by all enrollees. As passed by the Congress, 37 percent of costs are to be financed by fixed monthly premiums. The remaining costs are to be financed by an income-related "supplemental premium"--an income surtax that will affect less than half of enrollees. This income-related mechanism represents a major change in Medicare's financing.

This paper has four sections. The first section describes the new Medicare and related Medicaid benefits, in comparison to benefits as they were prior to passage of the act. The second section describes the financing provisions under the act. The third section simulates the impact the benefit and financing provisions would have had on Medicare enrollees if the provisions of the act had been fully effective throughout 1988. The fourth section concludes the discussion.

BENEFITS

The provisions of the act change Medicare's benefit structure significantly, but retain most current limits on preventive services

and long-term care. Major changes with their effective dates are described below, while Table 1 gives a more detailed comparison of benefits before and after full implementation of the act.

Hospital Insurance

For 1989, only Hospital Insurance (HI) benefits under Part A of Medicare will change, as follows:

> Hospital Inpatient Benefits. Acute-care hospital coverage will be unlimited. Medicare will pay all hospital inpatient costs above an annual deductible amount ($560 for 1989). Currently, the number of hospital days for which Medicare will pay in a single spell of illness is limited; enrollees may be liable for more than one hospital deductible; and coinsurance amounts are payable after the 60th day in each spell of illness.
>
> Skilled Nursing Facility (SNF) Benefits. The limit on SNF stays will be changed from 100 days in each spell to 150 days a year, and no prior hospital stay will be required. Coinsurance payments will be required only for the first 8 days each year, at 20 percent of average SNF costs per day ($25.50 for 1989). In 1988 under current law, coinsurance amounts of $67.50 are payable on days 21-100 in each spell of illness.
>
> Hospice Benefits. The current 210-day lifetime limit on hospice benefits will be eliminated, although a cost limit will remain. Small coinsurance requirements for drug and in-home respite expenses will continue.

Effective January 1990:

> Home Health Benefits. The current requirement that limits coverage for home health care to intermittent visits will be relaxed, so that enrollees may receive up to 38 consecutive days of care, 7 days a week. Current interpretation of the requirement that home health care be intermittent limits the frequency of visits to no more than five days a week, for up to three consecutive weeks. There is no limit on the overall number of visits and no coinsurance requirement for home health visits currently; this would not change under the act.

Supplementary Medical Insurance

Under Medicare Part B's Supplementary Medical Insurance (SMI) program, most services provided by physicians, outpatient clinics, and clinical laboratories are covered. Enrollees are responsible

TABLE 1. COMPARISON OF MEDICARE BENEFIT STRUCTURE BEFORE AND AFTER IMPLEMENTATION OF PUBLIC LAW 100-360

Provision	Before Implementation	After Implementation
	HOSPITAL INSURANCE (PART A) /a/	
Coverage	Hospital inpatient acute care. Short-term skilled nursing care. Intermittent home health care. Hospice care for terminally ill.	Same, with changes noted below.
Limits	Hospital stays limited to 90 days per spell of illness, plus up to 60 lifetime reserve days (with lifetime limit of 190 days for inpatient psychiatry). SNF stays limited to 100 days per spell, covered only subsequent to hospital stay of at least 3 days. Lifetime limit of 210 days for hospice. Consecutive days of home health care limited to 21.	No limit on covered inpatient days (except for psychiatric care where 190-day limit remains). SNF limit changed to 150 days a year, and no prior inpatient stay required for coverage. No limit on hospice days. Consecutive days of home health care limited to 38.
Deductibles	Inpatient deductible for first stay each spell. Blood deductible up to 3 units each spell.	Deductible for first stay each year. Blood deductible up to 3 units a year.
Coinsurance	Hospital coinsurance paid for days 61-90 (1/4 deductible) and for reserve days (1/2 deductible). SNF coinsurance paid for days 21-100 (1/8 deductible). Hospice coinsurance of 5% of drug/respite charges.	No hospital coinsurance. SNF coinsurance paid for days 1-8 each year (20% of daily cost).
	SUPPLEMENTARY MEDICAL INSURANCE and CATASTROPHIC DRUG INSURANCE (PART B)	
Coverage	Physicians' services. Hospital outpatient departments. Ambulatory surgicenters. Laboratory services. Intermittent home health care. Drugs for transplant patients (1 year only).	SMI program expanded to cover screening mammography and respite care. New Part B drug program introduced to cover prescription drugs and insulin.
Limits	Preventive services generally not covered. Reimbursement limit of $1,100 a year for outpatient psychiatric services.	Respite care limited to 80 hours a year, and available only to those who exceed SMI copayment cap or drug deductible in the previous 12 months.
Deductibles	Annual SMI deductible of $75.	Same, plus separate drug deductible set to affect 16.8% of enrollees.
Coinsurance	Coinsurance of 20% of reasonable charges above deductible amount (50% for outpatient psychiatry).	Same, subject to SMI copayment cap.
Copayment cap	None.	SMI copayment cap set to affect 7% of enrollees. No drug copayment cap.

SOURCE: Congressional Budget Office.

a. The act eliminated the spell of illness concept. A spell of illness began with a hospital admission and ended on the 61st day following discharge from the hospital or from a SNF entered subsequent to the hospital stay.

for an annual deductible amount of $75, and for 20 percent of reasonable charges above the deductible. There is no limit on enrollees' potential liabilities for copayments (deductible and coinsurance amounts) on covered services.1/ There is only very limited coverage for the costs of outpatient prescription drugs and for preventive services. Beginning in January of 1990, SMI benefits will be expanded as follows:

SMI Copayment Cap. Each enrollee's liability for SMI copayments will be capped ($1,370 in 1990). The cap will be adjusted each year to keep the proportion of enrollees affected constant at 7 percent.

Mammography. Coverage will be expanded to include screening mammography for women, subject to the usual copayment requirements.

Respite Care. Once incurring sufficient costs to receive benefits under either the SMI copayment cap or the new drug provisions (explained below), enrollees will be eligible for a respite benefit. Under this benefit, Medicare will pay 80 percent of reasonable costs for up to 80 hours a year of in-home personal services, to give homebound enrollees' usual caretakers a respite.

Catastrophic Drug Insurance

In addition, a new Catastrophic Drug Insurance (CDI) program will be phased in under Part B. Effective January 1990:

Limited Drug Benefits. Coverage will be provided for drugs administered intravenously at home and for immunosuppressive drugs after the first year following a transplant, subject to a deductible amount of $550. Coinsurance of 20 percent will be required on drugs administered intravenously, while coinsurance will initially be 50 percent for newly covered immunosuppressive drugs.2/

Effective January 1991, CDI will be further expanded:

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1. In addition to Medicare copayments, enrollees are liable for all Part B charges above Medicare's allowed amounts on unassigned claims--called balance-billing. Currently, more than 75 percent of Part B charges are assigned. Assigned claims are those for which providers bill Medicare directly, agreeing to accept Medicare's payment rates.

2. Medicare already covers 80 percent of the costs of immunosuppressive drugs in the first year following an organ transplant.

Full Drug Benefits. Coverage will include all outpatient prescription drugs and insulin, subject to a deductible amount ($600 in 1991) that will be adjusted each year to keep the proportion of enrollees affected constant at 16.8 percent. Enrollees' coinsurance requirements will be 50 percent of reasonable charges above the deductible in 1991, 40 percent in 1992, and 20 percent in 1993 and subsequent years.

The Congressional Budget Office (CBO) has estimated that new Medicare benefit and administrative costs for fiscal years 1989 through 1993 will total $30.8 billion. According to these estimates, about 34 percent of the five-year increase in payments for enrollees will be for HI benefits, 50 percent will be for SMI benefits, and 16 percent will be for drug benefits (Table 2).3/

Some Medicare enrollees will benefit as well from provisions under the act that expand Medicaid benefits. In particular, the act requires that, by 1992, federal-state Medicaid programs pay Medicare premium and copayment costs for those eligible for Part A benefits who are poor, even though they are not otherwise eligible for Medicaid benefits. In other words, states will be required to "buy in" this group of enrollees, where previously states had the option to do so. This benefit will be phased in, with Medicaid required to buy in all those below 85 percent of the poverty line in 1989, 90 percent in 1990, 95 percent in 1991, and 100 percent in 1992 and subsequent years.4/ The additional costs to Medicaid from the buy-in requirement will be largely offset by savings arising from the expansion of Medicare benefits. Because of the Medicare expansion, some costs currently paid by Medicaid for beneficiaries also eligible for Medicare will be picked up by Medicare.

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3. Appendix B gives CBO's complete cost estimate and a summary of the Administration's cost estimate for Public Law 100-360.

4. Two additional Medicaid benefits under the act do not interact with Medicare provisions. First, states will be required to allow spouses of nursing home residents seeking Medicaid coverage to retain more income than previously, to protect against spousal impoverishment. Second, Medicaid benefits will be extended to all pregnant women and infants living in families with incomes below the poverty line.

TABLE 2. NEW MEDICARE COSTS UNDER PUBLIC LAW 100-360 (By fiscal year, in millions of dollars)

Provision	1989	1990	1991	1992	1993	1989-1993
HOSPITAL INSURANCE						
No limit on hospital days	191	311	353	386	422	1663
No hospital coinsurance	341	544	609	660	714	2868
Maximum of 1 HI deductible	290	464	521	566	613	2454
Spell of illness hold harmless	119	61	0	0	0	180
Yearend protection on HI deductible	0	6	10	11	12	39
Maximum of 3 for blood deductible	6	9	10	11	12	48
No 3-day prior stay for SNF	40	51	61	72	82	306
SNF to 150 days, 20% coinsurance first 8 days	219	347	387	417	449	1819
No limit on hospice days	1	1	1	1	1	5
Home health to 38 consecutive days	0	126	182	194	208	710
Subtotal	1207	1920	2134	2318	2513	10092
SUPPLEMENTARY MEDICAL INSURANCE						
SMI copayment cap	0	1990	3289	3861	4362	13502
Screening mammography	0	81	127	140	149	497
Respite care /a/	0	53	127	207	329	716
Subtotal	0	2124	3543	4208	4840	14715
CATASTROPHIC DRUG INSURANCE						
Drug coverage	0	38	765	1621	2455	4879
Total Medicare Benefits	1207	4083	6442	8147	9807	29686
Total Administrative Costs	105	145	215	278	329	1072
Total	1312	4228	6657	8425	10136	30758
Copayment cap (projected after 1990)		1370	1530	1700	1900	
Percent of enrollees exceeding the cap		7.0%	7.0%	7.0%	7.0%	
Drug deductible (projected after 1992)		550	600	652	710	
Percent of enrollees exceeding the deductible		0.2%	16.8%	16.8%	16.8%	

SOURCE: Congressional Budget Office projections.

a. Only enrollees exceeding either copayment cap or drug deductible would be eligible for this benefit.

FINANCING

The cost of new Medicare benefits will be financed by additional premiums paid by enrollees. If Congressional projections of costs and enrollees' tax liabilities are realized, 37 percent of new Medicare costs will be covered by additional fixed monthly premiums paid by all Part B enrollees. The remaining 63 percent of costs will be covered by new income-related supplemental premiums. The supplemental premium will be payable by all those eligible for Part A benefits for at least six months of the year who have at least $150 in annual tax liability and who reside in one of the 50 states or the District of Columbia.5/ Liability for the monthly premium could be avoided by disenrolling from Part B; liability for the supplemental premium would be unaffected by disenrollment.

For 1989 through 1993, the new monthly and supplemental premium rates are set by law, at levels sufficient to cover projected costs plus a contingency margin to allow for projection error. For 1994 and subsequent years, rates will be increased from the previous year based on the historical growth in costs. For example, the increase in 1994 rates over 1993 values will reflect growth in costs for 1992 over 1991. In addition, rates will incorporate an adjustment to correct for inadequate or excess receipts in previous years, based on account balances at the end of the preceding year. That is, the Administration will look back to account balances at the end of 1992 in setting 1994 rates.

In 1989, Part B enrollees will pay a new monthly premium of $4.00 for new benefits under the act, in addition to the basic SMI premium of $27.90, for a total Part B premium of $31.90. As new benefits are phased in, the new monthly premium will increase annually, reaching a value of $10.20 in 1993, when the total monthly Part B premium is projected to be $42.60 (Table 3).

In addition, in 1989 an estimated 36 percent of Part A enrollees will be liable for the supplemental premium, in the form of a 15 percent income surtax (a tax on tax liability) for those with at least $150 of annual tax liability. Each enrollee's maximum supplemental liability will be limited by a ceiling, however, set at $800 for 1989. An estimated 5 percent of enrollees will pay

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5. B-only enrollees and residents of the territories or commonwealth will pay only a monthly premium for new benefits, with rates based on the insurance value of the new benefits provided to them.

TABLE 3. MEDICARE PREMIUMS PAYABLE PER ENROLLEE UNDER PUBLIC LAW 100-360 (By calendar year)

	1988	1989	1990	1991	1992	1993
MONTHLY PREMIUMS (In dollars per enrollee)						
Payable to catastrophic account		4.00	4.90	5.46	6.75	7.18
Payable to drug trust fund		0.00	0.00	1.94	2.45	3.02
New premiums (in law)		4.00	4.90	7.40	9.20	10.20
Current law premium (projected)	24.80	27.90	28.30	29.70	31.00	32.40
Total (projected)	24.80	31.90	33.20	37.10	40.20	42.60
SUPPLEMENTAL PREMIUMS (Annual surtax rates, in percents) /a/						
Payable to catastrophic account		15.0%	18.1%	20.1%	20.4%	19.7%
Payable to drug trust fund		0.0%	6.9%	5.9%	6.6%	8.3%
Total (in law)		15.0%	25.0%	26.0%	27.0%	28.0%
Maximum annual liability per enrollee		800	850	900	950	1050
Percent of enrollees paying maximum		5.1%	8.1%	8.8%	9.4%	9.8%
Percent of enrollees paying		35.6%	37.1%	39.0%	40.8%	42.5%
Average annual payment for those paying		285	400	430	461	506
AVERAGE ANNUAL MEDICARE PREMIUMS PAYABLE (In dollars per enrollee)						
For enrollees with no supplemental liability		383	398	445	482	511
For enrollees with supplemental liability		668	798	875	943	1017
For all enrollees		485	547	613	670	726

SOURCES: Congressional Budget Office for monthly premium information;
Joint Committee on Taxation for supplemental premium information.

a. Per dollar of tax liability. In law, rates are shown per $150 of tax liability.

this maximum amount in 1989. The supplemental rate will increase annually, reaching a value of 28 percent in 1993 (Table 3).6/

If current trends in cost growth continue, the new monthly premium would have to increase by about 10 percent annually in years after 1993 to keep pace with cost growth. By contrast, the supplemental rate could perhaps be held constant after 1993 (although the maximum liability would increase) because automatic growth in enrollees' supplemental liability may be sufficient to cover cost growth without further rate increases. The act prohibits reductions in both monthly and supplemental rates, and limits increases in the supplemental rate to at most one percentage point a year after 1993. There is no limit on increases in monthly premium rates after 1993.

IMPACT ON ENROLLEES

To assess the impact of the act on enrollees, this paper simulates its provisions as though they were fully effective throughout calendar year 1988. The impact estimates are for the entire Medicare population resident in the United States, whether they are enrolled in Part A, in Part B, or in both. In 1988, such enrollees will number about 32 million.7/

For the simulation, the SMI copayment cap was set to affect 7 percent of enrollees, and the drug deductible was set to affect

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6. For the supplemental calculation, couples filing jointly will divide their tax liability in half. If only one of the couple is eligible for HI benefits, the supplemental rate will apply to that person's half of tax liability, subject to the ceiling of $800 in 1989. If both are eligible for HI benefits, the rate will apply to both halves of the couple's tax liability, subject to a ceiling of $1,600 in 1989.

7. All but the surtax information was derived from simulations using a 1 percent sample of 1985 Medicare claims data, augmented by data on enrollees' drug costs from the last (1977) Current Medicare Survey (from the Health Care Financing Administration). Information about family income and medigap coverage was imputed onto this Medicare data base from the 1984 National Health Interview Survey (from the National Center for Health Statistics). Surtax information was derived from the March 1985 Current Population Survey (from the U.S. Bureau of the Census). The data bases were aged to 1988, consistent with CBO's baseline projections as of June 1988.

16.8 percent of enrollees.8/ The monthly premium rate was set to cover 37 percent of new benefit and administrative costs under the act--which would be an estimated $6.7 billion for a fully implemented benefit package in 1988. The supplemental premium rate was set to cover the remaining 63 percent of costs.9/ The ceiling on supplemental liability was set at 60 percent of the Part B "subsidy value," which is the per-enrollee value of part B benefits less monthly premiums payable.10/

Once the act is fully effective, about 22 percent of enrollees will be entitled to higher Medicare benefit payments because of either the HI provisions, the SMI copayment cap, or the new drug coverage. Medicare payments per enrollee would be higher by $194 (6.9 percent) if the act were fully implemented for 1988, for a total benefit payment of $2,995 (Table 4). HI payments would account for 28 percent of this increase, SMI payments for 43 percent, and drug payments for 29 percent. Most of the increase in benefit payments represents the assumption by Medicare of some portion of enrollees' current copayment liabilities. Under the act, enrollees' copayment liabilities would fall by $172, on average.11/ Medicare premiums payable would be higher by $207, on average, exceeding the increase in benefit payments by enough to cover the costs of administration and a contingency margin.

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8. The SMI copayment cap used for 1988 was $1,115; the drug deductible amount used was $465.

9. The monthly premium used for 1988 was $6.60 for Part B enrollees with Part A coverage (and $12.50 for B-only enrollees); the supplemental rate used was 30.5 percent, with a ceiling of $577.

10. Based on CBO's estimates, the ceiling specified for 1993 in the act will be 60 percent of the Part B subsidy value, and the relationship between the ceiling and the subsidy value in 1993 would be maintained in subsequent years because the ceiling would be indexed to the subsidy value.

11. Copayments are defined here to include drug costs, both before and after implementation of the act. Benefit payments would increase more than copayment liabilities would fall because of anticipated increases in use of services by enrollees in response to reduced cost-sharing and because of relaxation of some coverage limits.

TABLE 4. MEDICARE BENEFIT PAYMENTS, COPAYMENT LIABILITIES, AND PREMIUMS PAYABLE PER ENROLLEE BEFORE AND AFTER IMPLEMENTATION OF PUBLIC LAW 100-360, CALENDAR YEAR 1988

	Before	Change	After
Medicare benefit payments per enrollee /a/			
Hospital Insurance	1693	54	1747
Supplementary Medical Insurance	1108	83	1191
Catastrophic Drug Insurance	0	57	57
Total	2801	194	2995
Medicare copayment liabilities per enrollee			
Hospital Insurance	162	-44	118
Supplementary Medical Insurance	325	-63	262
Catastrophic Drug Insurance	244	-65	179
Total	731	-172	559
Medicare premiums payable per enrollee			
Monthly premiums	290	78	368
Supplemental premiums	0	129	129
Total	290	207	497

SOURCE: Congressional Budget Office simulation.

NOTE: Table shows effects of Medicare only.

a. About 22 percent of enrollees would be entitled to higher Medicare benefit payments under the act. This reflects an unduplicated count of those affected by the HI provisions (4 percent), the SMI copayment cap (7 percent), and the drug provisions (16.8 percent).

About 72 percent of Medicare enrollees currently have health benefits supplementary to Medicare, however, and the impact of the act on enrollees is affected by this supplementary coverage. The estimates shown in Tables 5-11 incorporate not only the effects of Medicare, but also of private medigap insurance and of Medicaid.12/ The adjustments made for enrollees' supplementary coverage are summarized below.

Medigap Insurance. About 62 percent of Medicare enrollees currently have medigap insurance designed to pick up most of their current Medicare copayment costs.13/ For these enrollees, Medicare copayment costs are reduced, and premium costs (if paid directly by enrollees) are higher, compared to enrollees who do not have medigap insurance. While a variety of medigap policies exist, the paper simulates a prototype that would cover all HI copayment costs and all SMI copayment costs above the $75 deductible. Balance-billing and drug costs would not be covered. For simulation, the medigap premium was set to achieve a "loss ratio" of 75 percent, which is within the range that is typical for medigap insurers. That is, 75 percent of receipts would be paid out in benefits, while the remainder would go for administrative costs and profit. It was assumed that medigap premiums would be paid directly by enrollees, not by current or former employers. The act would have no effect on HI and SMI copayment costs for enrollees with this medigap coverage, but it would reduce their drug and medigap premium costs.

Current Medicaid Coverage. About 10 percent of Medicare enrollees currently receive Medicaid benefits as well. For this group of dually eligible enrollees, there are typically no Medicare premium or copayment costs because these costs are paid by Medicaid. Further, this group would receive no new Medicare benefits under the act because the new benefits would accrue to Medicaid--reducing Medicaid costs--rather than to enrollees.

New Medicaid Buy-in Coverage. Another 8 percent of Medicare enrollees--those who are poor but are not now receiving Medicaid benefits--could potentially benefit from the new Medicaid buy-in requirement, under which Medicare premium and

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12. See Appendix Tables A-6 through A-11 for analogous results showing the effects of Medicare alone, for comparison to those shown in Tables 6-11.

13. Of those enrolled under both Parts A and B of Medicare, about 65 percent have medigap coverage. About a third of those with medigap insurance (or 20 percent of all Medicare enrollees) have part or all of their medigap premium costs paid by former employers.

copayment costs would be picked up by Medicaid. About 65 percent of those who would qualify for this new Medicaid benefit--or about 5 percent of Medicare enrollees--are expected to apply for it.14/

Under current law, the average benefit per enrollee--adjusted for medigap insurance and Medicaid coverage--will be an estimated $2,647 in 1988 (Table 5). Enrollees will face adjusted copayment costs of $380, on average. If the act had been fully effective in 1988, the average Medicare benefit would have been higher by $130, for a total benefit of $2,777. Copayment costs would have been lower by $110, on average, falling to 71 percent of current copayment costs (including drug costs). Adjusted premiums would increase by $114. The change in adjusted premiums would be less than the change in adjusted benefits because of the new Medicaid coverage of all Medicare premium costs for poor enrollees.

Adjusted benefits currently received by poor enrollees ($1,765) are less than the average benefit ($2,647) because Medicare benefits accrue to Medicaid for enrollees who are dually eligible (Table 6). The increase in adjusted benefits under the act would, however, be significantly larger than average for poor enrollees ($275, compared to an average increase of $130), largely because Medicaid will assume responsibility for copayment costs for poor enrollees not already receiving Medicaid benefits.

No enrollee would have been liable for copayments in excess of $2,500 had all the provisions of the act been in place in 1988, while currently nearly 2 percent of enrollees face such high copayment costs (Table 7). Elimination of the risk of very high copayment costs is an effect that is largely focused on Medicare enrollees who lack supplementary coverage, a group that tends to be poorer, older, and in poorer health than enrollees who have medigap insurance.15/ The 10 percent of enrollees who are dually eligible for Medicaid now generally have no copayment costs. Enrollees who have medigap insurance have negligible copayment costs for HI and SMI benefits, although they may face significant costs for prescription drugs. Of the 62 percent of enrollees with medigap coverage, only 0.5 percent currently have copayment costs in excess of $2,500. By contrast, of the 28 percent of enrollees with only Medicare coverage, more than 5 percent incur copayment costs in excess of $2,500.

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14. New Medicaid benefits for spousal income protection and for pregnant women and infants are not included in the results shown.

15. See Christensen, Long, and Rodgers," Acute Health Care Costs for the Aged Medicare Population," Milbank Quarterly, vol. 65, no. 3, 1987.

TABLE 5. ADJUSTED BENEFITS, COPAYMENTS, AND PREMIUM COSTS PER MEDICARE ENROLLEE BEFORE AND AFTER IMPLEMENTATION OF PUBLIC LAW 100-360, CALENDAR YEAR 1988

	Before	Change	After
Medicare benefit payments per enrollee	2801	194	2995
Adjustments for /a/			
Medigap Insurance	251	-62	189
Current Medicaid Benefits	-405	-30	-435
New Medicaid Buy-in	0	28	28
Adjusted benefits per enrollee	2647	130	2777
Medicare copayment liabilities per enrollee	731	-172	559
Adjustments for /b/			
Medigap Insurance	-251	62	-189
Current Medicaid Benefits	-100	28	-72
New Medicaid Buy-in	0	-28	-28
Adjusted copayments per enrollee	380	-110	270
Medicare premiums payable per enrollee	290	207	497
Adjustments for /c/			
Medigap Insurance	334	-65	270
Current Medicaid Benefits	-31	-9	-40
New Medicaid Buy-in	0	-19	-19
Adjusted premiums per enrollee	593	114	708

SOURCE: Congressional Budget Office simulation.

NOTE: Table shows combined effects of Medicare, Medicaid, and medigap insurance for services covered by Medicare.

a. Medigap insurance would increase benefits because of the copayment costs it covers; current Medicaid coverage would reduce benefits because benefits would accrue to Medicaid; the new Medicaid buy-in would increase benefits by reducing poor enrollees' copayment costs.

b. Medigap insurance, current Medicaid coverage, and the new Medicaid buy-in would reduce enrollees' copayment costs by picking up some or all of them.

c. Medigap coverage would increase total premium costs, while Medicaid coverage would reduce premium costs because Medicaid would pay these costs for eligible enrollees.

TABLE 6. ADJUSTED BENEFITS PER ENROLLEE BY INCOME AND POVERTY STATUS BEFORE AND AFTER IMPLEMENTATION OF PUBLIC LAW 100-360, CALENDAR YEAR 1988

	Percent of enrollees in group	Benefits per Enrollee		
		Before	Change	After
By Per Capita Income Percentiles (Average Per Capita Income)				
0 to 10 ($2,881)	10.0%	2052	243	2295
11 to 30 ($5,623)	20.0%	2500	160	2660
31 to 50 ($8,575)	20.0%	2724	113	2837
51 to 70 ($12,604)	20.0%	2813	112	2924
71 to 90 ($19,579)	20.0%	2844	101	2945
91 to 100 ($52,291)	10.0%	2654	91	2744
By Poverty Status				
Poor	12.8%	1765	275	2040
Near poor /a/	19.4%	2822	124	2946
Other	67.8%	2764	105	2869
All Enrollees	100.0%	2647	130	2777

SOURCE: Congressional Budget Office simulation.

NOTE: Table shows combined effects of Medicare, Medicaid, and medigap insurance for services covered by Medicare.

a. Includes those with incomes above the poverty line but below 1.5 times the line.

TABLE 7. PERCENT DISTRIBUTION OF ENROLLEES BY INSURANCE COVERAGE AND ADJUSTED COPAYMENT CATEGORY BEFORE AND AFTER IMPLEMENTATION OF PUBLIC LAW 100-360, CALENDAR YEAR 1988

Copayment Category	Percent of Enrollees in Group	Percent Distribution		Average Copayment	
		Before	After	Before	After
All Medicare Enrollees	100.0%	100.0%	100.0%	380	270
$0		12.7%	17.9%	0	0
$1-500		65.5%	62.0%	155	157
$501-1,500		16.8%	17.7%	843	721
$1,501-2,500		3.2%	2.4%	1918	1865
$2,501 or more		1.7%	0.0%	4324	--
Enrollees with Medicare and Medicaid	10.5%	100.0%	100.0%	0	0
$0		100.0%	100.0%	0	0
$1-500		0.0%	0.0%	--	--
$501-1,500		0.0%	0.0%	--	--
$1,501-2,500		0.0%	0.0%	--	--
$2,501 or more		0.0%	0.0%	--	--
Enrollees with Medicare and Medigap	61.9%	100.0%	100.0%	312	238
$0		0.0%	3.3%	0	0
$1-500		81.0%	78.6%	159	160
$501-1,500		17.0%	18.2%	796	615
$1,501-2,500		1.5%	0.0%	1893	--
$2,501 or more		0.5%	0.0%	4083	--
Enrollees with Only Medicare	27.5%	100.0%	100.0%	680	447
$0		7.9%	19.2%	0	0
$1-500		55.7%	48.6%	144	146
$501-1,500		22.8%	23.4%	922	905
$1,501-2,500		8.4%	8.8%	1927	1866
$2,501 or more		5.2%	0.0%	4378	--

SOURCE: Congressional Budget Office simulation.

NOTE: Table shows combined effects of Medicare, Medicaid, and medigap insurance for services covered by Medicare. Enrollee groups defined by insurance coverage before Public Law 100-360.

The extent to which copayment costs would be reduced under a fully implemented act for enrollees without supplementary coverage can be seen more clearly by defining fixed enrollee groups, based on use of services (Table 8). Enrollees with long hospital stays who lack supplementary coverage face copayment costs in excess of $8,100 currently, and would on average see those costs reduced by more than $6,500 under the act. The reduction in average copayment costs under the act is estimated to be more than three times as large for enrollees with only Medicare coverage as for enrollees with medigap insurance.

This new protection against very high copayment costs for Medicare enrollees currently without supplementary coverage was one of the major objectives of the act. The Congress attempted to ensure that the full value of new Medicare benefits would accrue in some form to enrollees with medigap insurance as well, although attainment of this goal is uncertain. The act requires that medigap policies sold directly to enrollees eliminate provisions that duplicate Medicare's new benefits, and encourages insurers either to reduce premiums or to provide alternative benefits of equal value.16/ If medigap insurers were to reduce premiums, as the simulation assumes, the 1988 premium for the prototype medigap policy examined here would have dropped from $540 to $450.

The effects of the new Medicaid buy-in requirement are seen most sharply in changes in copayment and premium costs by poverty status. Estimated copayment costs for poor enrollees would have been reduced by $252, to only $88 on average, if the act had been fully effective in 1988 (Table 9). Currently, average copayments for poor enrollees are $340, reflecting costs for the two-thirds of this group who do not now receive Medicaid benefits. If the simulation had assumed that all those who would be eligible for the new Medicaid buy-in would apply for it, however, copayment costs for poor enrollees would have been zero.

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16. A similar requirement for premium rebates or alternative benefits was imposed on some employers who provide medigap benefits to current or former employees. Employers who currently provide medigap benefits equal to or greater than half the national average would be subject to the requirement, while employers whose medigap benefits are less than half the national average could allow new Medicare benefits to reduce their insurance costs instead. The desire of unions to enforce maintenance of effort and of employers to be "good" could work against the latter response, however.

TABLE 8. ADJUSTED COPAYMENTS PER ENROLLEE BY INSURANCE COVERAGE AND USE OF SERVICES BEFORE AND AFTER IMPLEMENTATION OF PUBLIC LAW 100-360, CALENDAR YEAR 1988

Enrollee Group	Percent of Enrollees in Group	Copayment Costs per Enrollee		
		Before	Change	After
All Medicare Enrollees	100.0%	380	-110	270
No reimbursable services	28.3%	117	-40	77
No stays, other services	50.2%	343	-82	261
One stay, no coinsurance	14.1%	671	-158	513
2+ stays, no coinsurance	6.8%	965	-356	609
1+ stays, coinsurance days	0.5%	2712	-2060	652
Enrollees with Medicare and Medicaid	10.5%	0	0	0
No reimbursable services	1.8%	0	0	0
No stays, other services	6.0%	0	0	0
One stay, no coinsurance	1.7%	0	0	0
2+ stays, no coinsurance	1.0%	0	0	0
1+ stays, coinsurance days	0.1%	0	0	0
Enrollees with Medicare and Medigap	61.9%	312	-74	238
No reimbursable services	16.2%	136	-43	93
No stays, other services	32.7%	337	-72	265
One stay, no coinsurance	8.7%	447	-112	335
2+ stays, no coinsurance	4.0%	512	-135	377
1+ stays, coinsurance days	0.3%	515	-156	359
Enrollees with Only Medicare	27.5%	680	-233	447
No reimbursable services	10.3%	106	-40	66
No stays, other services	11.6%	539	-156	383
One stay, no coinsurance	3.7%	1518	-344	1174
2+ stays, no coinsurance	1.8%	2502	-1041	1461
1+ stays, coinsurance days	0.2%	8116	-6556	1560

SOURCE: Congressional Budget Office simulation.

NOTE: Table shows combined effects of Medicare, Medicaid, and medigap insurance for services covered by Medicare. Enrollee groups defined by use and insurance coverage before Public Law 100-360.

TABLE 9. ADJUSTED COPAYMENTS PER ENROLLEE BY INCOME AND POVERTY STATUS BEFORE AND AFTER IMPLEMENTATION OF PUBLIC LAW 100-360, CALENDAR YEAR 1988

	Percent of Enrollees in Group	Copayment Costs per Enrollee		
		Before	Change	After
By Per Capita Income Percentiles (Average Per Capita Income)				
0 to 10 ($2,881)	10.0%	367	-219	148
11 to 30 ($5,623)	20.0%	390	-136	253
31 to 50 ($8,575)	20.0%	390	-92	298
51 to 70 ($12,604)	20.0%	390	-92	299
71 to 90 ($19,579)	20.0%	375	-83	292
91 to 100 ($52,291)	10.0%	350	-76	274
By Poverty Status				
Poor	12.8%	340	-252	88
Near poor /a/	19.4%	405	-98	307
Other	67.8%	381	-87	294
All Enrollees	100.0%	380	-110	270

SOURCE: Congressional Budget Office simulation.

NOTE: Table shows combined effects of Medicare, Medicaid, and medigap insurance for services covered by Medicare.

a. Includes those with incomes above the poverty line but below 1.5 times the line.

Premium costs, too, will fall for poor enrollees under the act. In part, this is because Medicaid will not only pick up new Medicare premiums, but will also pay existing Part B premium costs for the poor. In addition, the simulation assumes that beneficiaries of the new Medicaid buy-in will drop any medigap insurance they have (because they would have no Medicare copayment costs for medigap to pick up), thereby eliminating those premium costs. Had the provisions of the act been fully implemented in 1988, premium costs for poor enrollees would have been lower by an estimated $194--falling to $122 from $316 (Table 10). Again, if the simulation had assumed that all enrollees eligible for the new Medicaid buy-in would apply for it--and simultaneously would drop their medigap coverage--premium costs would have been eliminated for all poor enrollees.

The net result of the act if it were fully effective in 1988 would be to reduce out-of-pocket costs (direct costs plus premiums) for poor and near-poor enrollees, while increasing costs for other groups (Table 11). Out-of-pocket costs for poor enrollees would fall by $469, on average, because of reductions in both direct costs and premiums. For near-poor enrollees, out-of-pocket costs would fall by $105, on average, as the result of lower direct costs partially offset by higher premium costs. (For near-poor enrollees not eligible for Medicaid, medigap premiums would fall, while Medicare premium costs would increase by the amount of the new fixed premiums. For those who now receive Medicaid benefits, premiums would be unchanged.) By contrast, more than half of enrollees with incomes more than 1.5 times the poverty line would be liable for the supplemental premium as well as the new monthly premiums, so that their total premium costs would increase by $199 for 1988, on average. This is larger than the expected decline in direct costs for this group, so that average out-of-pocket costs would increase by $94.

TABLE 10. ADJUSTED PREMIUM COSTS PER ENROLLEE BY INCOME AND POVERTY STATUS BEFORE AND AFTER IMPLEMENTATION OF PUBLIC LAW 100-360, CALENDAR YEAR 1988

	Percent of Enrollees in Group	Premium Costs per Enrollee		
		Before	Change	After
By Per Capita Income Percentiles (Average Per Capita Income)				
0 to 10 ($2,881)	10.0%	343	-139	204
11 to 30 ($5,623)	20.0%	470	-34	436
31 to 50 ($8,575)	20.0%	592	23	614
51 to 70 ($12,604)	20.0%	664	89	753
71 to 90 ($19,579)	20.0%	698	302	1000
91 to 100 ($52,291)	10.0%	740	522	1262
By Poverty Status				
Poor	12.8%	316	-194	122
Near poor /a/	19.4%	503	19	522
Other	67.8%	671	199	870
All Enrollees	100.0%	593	114	708

SOURCE: Congressional Budget Office simulation.

NOTE: Table shows combined effects of Medicare, Medicaid, and medigap insurance for services covered by Medicare.

a. Includes those with incomes above the poverty line but below 1.5 times the line.

TABLE 11. NET CHANGE IN ENROLLEES' ADJUSTED OUT-OF-POCKET COSTS BY INCOME AND POVERTY STATUS BEFORE AND AFTER IMPLEMENTATION OF PUBLIC LAW 100-360, CALENDAR YEAR 1988

	Percent of Enrollees in Group	Net Change in: /a/ Direct Costs	Premium Costs	Total Costs
By Per Capita Income Percentiles (Average Per Capita Income)				
0 to 10 ($2,881)	10.0%	-243	-139	-382
11 to 30 ($5,623)	20.0%	-160	-34	-194
31 to 50 ($8,575)	20.0%	-113	23	-90
51 to 70 ($12,604)	20.0%	-112	89	-22
71 to 90 ($19,579)	20.0%	-101	302	202
91 to 100 ($52,291)	10.0%	-91	522	431
By Poverty Status				
Poor	12.8%	-275	-194	-469
Near poor /b/	19.4%	-124	19	-105
Other	67.8%	-105	199	94
All Enrollees	100.0%	-130	114	-16

SOURCE: Congressional Budget Office simulation.

NOTE: Table shows combined effects of Medicare, Medicaid, and medigap insurance for services covered by Medicare.

a. Direct costs are adjusted benefits under the act.

b. Includes those with incomes above the poverty line but below 1.5 times the line.

CONCLUSION

Considering only the effects of the new provisions, the Medicare Catastrophic Coverage Act will generate a financial gain for lower-income enrollees, and a financial loss for high-income groups--although all enrollees will continue to receive a subsidy on total benefits under Medicare.17/

Because new Medicare costs under the act are paid entirely by enrollees, new premiums must exceed new benefit payments, overall, to cover the additional costs of administration and required contingency margins. Because only 37 percent of costs are paid by monthly premiums, while remaining costs are concentrated on the minority of enrollees with supplemental liability, new premium liabilities will be less than new benefit payments for lower-income enrollees, and will exceed new benefit payments for upper-income groups--those above the 70th percentile (Table 12).

The financial loss for high-income enrollees would be smaller, although not eliminated, if the copayment limits provided under the act were sufficient to induce enrollees to drop their medigap insurance altogether.18/ For the highest-income decile, total enrollee costs under the act would have been higher by $431, on average for 1988, while medigap premium costs would have been about $450. By dropping medigap coverage, enrollees could expect to save a little over $100, after allowing for the additional medical costs they would have to pay directly.

Nevertheless, all enrollees will continue to receive a substantial subsidy on total benefit payments under Medicare, and some subsidy even when only Part B benefit payments are considered. On average, if the act had been fully implemented in 1988, enrollees' Medicare premiums would have covered less than 17 percent of Medicare benefit costs. This assumes, however, that enrollees' HI benefits are entirely subsidized by current payroll taxes from other groups. If, instead, HI benefit costs are subtracted from the Medicare benefit total--to reflect the belief of many beneficiaries

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17. Benefits for low-income enrollees would be even larger if the effects of the new spousal income protection were included in the analysis, but beneficiaries of this provision cannot be identified in the data.

18. Dropping medigap coverage in response to the new Medicare benefit package is a second-order effect that was not included in the simulations for any enrollee group except those who would benefit from the new Medicaid buy-in requirement.

TABLE 12. MEDICARE PREMIUMS PAYABLE AS A PERCENT OF MEDICARE BENEFIT PAYMENTS AFTER IMPLEMENTATION OF PUBLIC LAW 100-360, CALENDAR YEAR 1988

	New Premiums as Percent of New Benefit Payments	Total Premiums as Percent of Total Benefit Payments When HI Benefits Are: Included	Excluded
By Per Capita Income Percentiles (Average Per Capita Income)			
0 to 10 ($2,881)	33.5%	11.0%	26.5%
11 to 30 ($5,623)	36.5%	11.2%	27.3%
31 to 50 ($8,575)	45.5%	12.4%	30.1%
51 to 70 ($12,604)	83.3%	15.5%	36.7%
71 to 90 ($19,579)	218.9%	23.8%	57.0%
91 to 100 ($52,291)	371.7%	35.5%	81.1%
By Poverty Status			
Poor	34.5%	11.4%	26.5%
Near poor /a/	35.0%	10.6%	26.7%
Other	150.7%	19.9%	47.2%
All Enrollees	106.7%	16.6%	39.8%

SOURCE: Congressional Budget Office simulation.

NOTE: Table shows effects of Medicare only.

a. Includes those with incomes above the poverty line but below 1.5 times the line.

that they paid the full cost of these benefits through payroll taxes during their working years--premiums would represent about 40 percent of Part B benefit costs, on average.19/ Even for enrollees in the highest-income decile--who would typically incur the maximum supplemental liability--premium payments would only cover 81 percent of Part B benefit costs. Thus, even for this least-subsidized group of enrollees, Medicare benefit payments would exceed Medicare premiums payable by 23 percent or more.

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19. In fact, a typical man reaching age 65 in January of 1989 would have accumulated HI payroll tax contributions (including his own and his employer's share, plus interest) sufficient to cover only about 36 percent of HI benefits expected over his remaining lifetime (15 years). A man who had paid the maximum HI payroll tax each year through 1988 would have accumulated contributions sufficient to cover about 68 percent of expected benefits. Because a woman's expected lifetime at age 65 is longer (19 years), any given history of payroll tax contributions would cover a smaller percent of her expected benefits.

APPENDIX A. IMPACT ESTIMATES FOR PUBLIC LAW 100-360 SHOWING EFFECTS OF MEDICARE ONLY (WITHOUT ADJUSTMENT FOR MEDICAID AND MEDIGAP INSURANCE)

TABLE A-6. MEDICARE BENEFITS PER ENROLLEE BY INCOME AND POVERTY STATUS BEFORE AND AFTER IMPLEMENTATION OF PUBLIC LAW 100-360, CALENDAR YEAR 1988

	Percent of Enrollees in Group	Benefits per Enrollee		
		Before	Change	After
By Per Capita Income Percentiles (Average Per Capita Income)				
0 to 10 ($2,881)	10.0%	3098	237	3335
11 to 30 ($5,623)	20.0%	3099	221	3320
31 to 50 ($8,575)	20.0%	2865	195	3060
51 to 70 ($12,604)	20.0%	2705	189	2894
71 to 90 ($19,579)	20.0%	2617	171	2787
91 to 100 ($52,291)	10.0%	2339	161	2499
By Poverty Status				
Poor	12.8%	3012	232	3244
Near poor /a/	19.4%	3263	226	3489
Other	67.8%	2629	178	2807
All Enrollees	100.0%	2801	194	2995

SOURCE: Congressional Budget Office simulation.

NOTE: Table shows effects of Medicare only.

a. Includes those with incomes above the poverty line but below 1.5 times the line.

TABLE A-7. PERCENT DISTRIBUTION OF ENROLLEES BY COPAYMENT CATEGORY BEFORE AND AFTER IMPLEMENTATION OF PUBLIC LAW 100-360, CALENDAR YEAR 1988

	Percent Distribution		Average Copayment	
Copayment Category	Before	After	Before	After
All Medicare Enrollees	100.0%	100.0%	731	559
$0	2.2%	2.2%	0	0
$1-500	57.8%	57.8%	159	160
$501-1,500	25.1%	29.3%	926	909
$1,501-2,500	9.3%	10.7%	1921	1861
$2,501 or more	5.5%	0.0%	4104	--

SOURCE: Congressional Budget Office simulation.

NOTE: Table shows effects of Medicare only.

TABLE A-8. MEDICARE COPAYMENTS PER ENROLLEE BY USE OF SERVICES
BEFORE AND AFTER IMPLEMENTATION OF PUBLIC LAW 100-360, CALENDAR YEAR 1988

Enrollee Group	Percent of Enrollees in Group	Copayment Costs per Enrollee		
		Before	Change	After
All Medicare Enrollees	100.0%	731	-172	559
No reimbursable services	28.3%	125	-36	89
No stays, other services	50.2%	532	-93	439
One stay, no coinsurance	14.1%	1540	-195	1345
2+ stays, no coinsurance	6.9%	2486	-817	1669
1+ stays, coinsurance days	0.5%	7923	-6103	1820

SOURCE: Congressional Budget Office simulation.

NOTE: Table shows effects of Medicare only. Enrollee groups defined by use before Public Law 100-360.

TABLE A-9. MEDICARE COPAYMENTS PER ENROLLEE BY INCOME AND POVERTY STATUS
BEFORE AND AFTER IMPLEMENTATION OF PUBLIC LAW 100-360, CALENDAR YEAR 1988

	Percent of Enrollees in Group	Copayment Costs per Enrollee		
		Before	Change	After
By Per Capita Income Percentiles (Average Per Capita Income)				
0 to 10 ($2,881)	10.0%	781	-205	576
11 to 30 ($5,623)	20.0%	777	-192	585
31 to 50 ($8,575)	20.0%	737	-172	565
51 to 70 ($12,604)	20.0%	718	-168	550
71 to 90 ($19,579)	20.0%	701	-153	548
91 to 100 ($52,291)	10.0%	665	-147	519
By Poverty Status				
Poor	12.8%	774	-202	572
Near poor /a/	19.4%	803	-196	607
Other	67.8%	703	-160	543
All Enrollees	100.0%	731	-172	559

SOURCE: Congressional Budget Office simulation.

NOTE: Table shows effects of Medicare only.

a. Includes those with incomes above the poverty line but below 1.5 times the line.

TABLE A-10. MEDICARE PREMIUM COSTS PER ENROLLEE BY INCOME AND POVERTY STATUS BEFORE AND AFTER IMPLEMENTATION OF PUBLIC LAW 100-360, CALENDAR YEAR 1988

	Percent of Enrollees in Group	Premium Costs per Enrollee		
		Before	Change	After
By Per Capita Income Percentiles (Average Per Capita Income)				
0 to 10 ($2,881)	10.0%	289	80	368
11 to 30 ($5,623)	20.0%	290	81	371
31 to 50 ($8,575)	20.0%	290	89	379
51 to 70 ($12,604)	20.0%	291	157	448
71 to 90 ($19,579)	20.0%	290	373	663
91 to 100 ($52,291)	10.0%	291	597	887
By Poverty Status				
Poor	12.8%	289	80	369
Near poor /a/	19.4%	290	79	369
Other	67.8%	290	268	558
All Enrollees	100.0%	290	207	497

SOURCE: Congressional Budget Office simulation.

NOTE: Table shows effects of Medicare only.

a. Includes those with incomes above the poverty line but below 1.5 times the line.

TABLE A-11. NET CHANGE IN ENROLLEES' OUT-OF-POCKET COSTS BY INCOME AND POVERTY STATUS BEFORE AND AFTER IMPLEMENTATION OF PUBLIC LAW 100-360, CALENDAR YEAR 1988

	Percent of Enrollees in Group	Net Change in: /a/		
		Direct Costs	Premium Costs	Total Costs
By Per Capita Income Percentiles (Average Per Capita Income)				
0 to 10 ($2,881)	10.0%	-237	80	-158
11 to 30 ($5,623)	20.0%	-221	81	-140
31 to 50 ($8,575)	20.0%	-195	89	-106
51 to 70 ($12,604)	20.0%	-189	157	-32
71 to 90 ($19,579)	20.0%	-171	373	203
91 to 100 ($52,291)	10.0%	-161	597	436
By Poverty Status				
Poor	12.8%	-232	80	-152
Near poor /b/	19.4%	-226	79	-147
Other	67.8%	-178	268	90
All Enrollees	100.0%	-194	207	13

SOURCE: Congressional Budget Office simulation.

NOTE: Table shows effects of Medicare only.

a. Direct costs are Medicare benefits under the act.
b. Includes those with incomes above the poverty line but below 1.5 times the line.

APPENDIX B. COST ESTIMATES FOR PUBLIC LAW 100-360

TABLE B-1. SUMMARY OF BUDGET EFFECTS FOR PUBLIC LAW 100-360 (By fiscal year, in millions of dollars)

	1988	1989	1990	1991	1992	1993	1988-1993
MEDICARE NONDRUG PROVISIONS							
Benefits	0	1207	4044	5677	6526	7353	24807
Administration	0	73	52	52	50	52	278
Monthly Premiums	0	-1106	-1810	-2120	-2601	-2909	-10545
Supplemental Premiums	0	-315	-3857	-3644	-4346	-4799	-16960
Subtotal	0	-141	-1570	-34	-371	-304	-2420
MEDICARE DRUG PROVISIONS							
Benefits	0	0	38	765	1621	2455	4879
Administration	5	32	94	163	229	277	798
Monthly Premiums	0	0	-3	-582	-970	-1212	-2767
Supplemental Premiums	0	0	-390	-1278	-1318	-1712	-4699
Subtotal	5	32	-261	-933	-438	-192	-1788
NET MEDICARE EFFECT	5	-109	-1832	-967	-809	-496	-4208
MEDICAID/OTHER HEALTH PROVISIONS							
Offsets from Medicare Provisions	0	-45	-247	-398	-495	-605	-1790
Medicaid Buyin for Medicare	0	106	231	435	591	665	2028
Spousal Protection	0	-6	358	339	210	229	1130
Pregnant Women/Infants	0	5	50	125	160	195	535
OBRA-87 Technical Amendments/Other	0	-15	-4	0	8	11	0
NET MEDICAID/OTHER HEALTH EFFECT	0	45	388	501	474	495	1903
NET BUDGET EFFECT	5	-64	-1444	-466	-335	-1	-2305
Supplemental Receipts /a/	0	-315	-4247	-4922	-5664	-6511	-21659
Outlays/Direct Spending	0	146	2657	4242	5050	6182	18277
Outlays/Appropriated	5	105	145	215	278	329	1077
NET BUDGET EFFECT	5	-64	-1444	-466	-335	-1	-2305

SOURCE: Congressional Budget Office. 24-June-88

NOTE: Because premium rates would be fixed in law, with no provision for adjustment before 1994 to reflect changing circumstances, budget and trust fund effects will probably differ from those shown.

a. Receipts are shown with a negative sign, indicating their effect on the budget.

TABLE B-2. MEDICARE BENEFIT COSTS UNDER PUBLIC LAW 100-360 (By fiscal year, in millions of dollars)

	1988	1989	1990	1991	1992	1993	1988-1993
No 3-day prior stay for SNF		40	51	61	72	82	306
No limit on hospital days		191	311	353	386	422	1663
No hospital coinsurance		341	544	609	660	714	2868
Maximum of 1 HI deductible		290	464	521	566	613	2454
Spell of illness hold harmless		119	61	0	0	0	180
Yearend protection on HI deductible		0	6	10	11	12	39
No limit on hospice days		1	1	1	1	1	5
Maximum of 3 for blood deductible		6	9	10	11	12	48
Change in SNF coinsurance:							
20% of costs for first 8 days		219	347	387	417	449	1819
Home health expansion:							
Up to 38 consecutive days		0	126	182	194	208	710
Respite care (80 hours/cy) /a/		0	53	127	207	329	716
Screening mammography ($50 limit)		0	81	127	140	149	497
Copayment Cap /b/		0	1990	3289	3861	4362	13502
CATASTROPHIC TOTAL		1207	4044	5677	6526	7353	24807
Drug Coverage /c/		0	38	765	1621	2455	4879
MEDICARE TOTAL		1207	4083	6442	8147	9807	29686
Base HI premium on insurance value		16	21	22	22	23	104
Hold-harmless protection for SMI premiums		13	12	10	10	9	54

SOURCE: Congressional Budget Office. 24-June-88

a. Only enrollees hitting either the copayment cap or the drug deductible would be eligible for this benefit.

b. Copayment cap	1370	1530	1700	1900
Percent of enrollees affected	7.0%	7.0%	7.0%	7.0%
c. Drug deductible	550	600	652	710
Percent of enrollees affected	0.2%	16.8%	16.8%	16.8%

TABLE B-3. ADMINISTRATIVE COSTS UNDER PUBLIC LAW 100-360 (By fiscal year, in millions of dollars)

	1988	1989	1990	1991	1992	1993	1988-1993
Administration of Copayment Cap	0	45	25	26	27	28	151
Participating Physician Directories	0	11	12	13	13	14	63
Beneficiary Notification	0	4	4	4	4	5	22
Counseling Demonstration	0	3	3	3	0	0	8
Case Management Demonstration	0	2	2	0	0	0	4
Bipartisan Commission	0	2	0	0	0	0	2
Longterm Care Study	0	5	5	5	5	5	25
Home Health Advisory Committee	0	1	0	0	0	0	1
Ventilator Demonstration/Study	0	1	1	1	0	0	3
CATASTROPHIC TOTAL	0	73	52	52	50	52	278
Administration of drug benefit	5	31	92	160	226	274	786
Drug Payment Review Commission	0	0	2	3	3	3	11
Survey of drug costs (NMES)	0	1	0	0	0	0	1
DRUG TOTAL	5	32	94	163	229	277	798
MEDICARE TOTAL	5	105	145	215	278	329	1077

SOURCE: Congressional Budget Office. 24-June-88

TABLE B-4. MEDICARE PREMIUMS PAYABLE UNDER PUBLIC LAW 100-360 (By calendar year)

	1988	1989	1990	1991	1992	1993
MONTHLY PREMIUMS (In dollars per enrollee per month)						
New catastrophic		4.00	4.90	5.46	6.75	7.18
New drug		0.00	0.00	1.94	2.45	3.02
Total new premiums	0.00	4.00	4.90	7.40	9.20	10.20
Current law premium /a/	24.80	27.10	28.30	29.70	31.00	32.40
Total monthly premium /a/	24.80	31.10	33.20	37.10	40.20	42.60
AVERAGE SUPPLEMENTAL PREMIUM (In dollars per enrollee per month) /b/						
Catastrophic portion		8.12	8.62	10.46	11.48	12.24
Drug portion		0.00	3.29	3.06	3.75	5.17
Total supplemental premium	0.00	8.12	11.91	13.52	15.23	17.41
MONTHLY AND SUPPLEMENTAL PREMIUMS AS A PERCENT OF BENEFITS						
Average New Premium (per month)		12.12	16.81	20.92	24.43	27.61
Average New Benefit (per month) /c/		5.17	14.28	19.82	22.61	26.87
New Premiums as a Percent of New Benefits		234.3%	117.7%	105.5%	108.1%	102.8%
Average Total Premium (per month)	24.80	39.22	45.11	50.62	55.43	60.01
Average Total Benefit (per month)	240.43	266.02	301.99	334.00	366.72	402.82
Premiums as a Percent of Total Benefits	10.3%	14.7%	14.9%	15.2%	15.1%	14.9%
Maximum Premium as a Percent of SMI Benefits		90.6%	80.4%	75.2%	71.3%	68.8%

SOURCE: Congressional Budget Office. 24-June-88

a. The Health Care Financing Administration later announced that the current law premium for 1989 would be $27.90, for a total monthly premium of $31.90 in 1989.

b. In 1993, 63% of revenues would be income-related, 37% would be fixed.
Supplemental (income-related) rates and related information are shown below.

Per dollar of tax liability each year	0.15	0.25	0.26	0.27	0.28
Per $150 of tax liability each year	22.50	37.50	39.00	40.50	42.00
Percent of enrollees paying	35.6%	37.1%	39.0%	40.8%	42.5%
Average monthly payment for payers	22.81	32.11	34.67	37.33	40.96
Annual maximum per enrollee	800	850	900	950	1050
Percent of enrollees paying maximum	5.1%	8.1%	8.8%	9.4%	9.8%

c. The bill would provide Medicaid benefits in addition to the new Medicare benefits shown here.

TABLE B-5. MEDICARE TRUST FUND EFFECTS UNDER PUBLIC LAW 100-360 (By calendar year, in millions of dollars)

	1988	1989	1990	1991	1992	1993
CURRENT HI AND SMI TRUST FUNDS (Exclusive of CDI trust fund)						
MARGINAL EFFECT ON HI TRUST FUND (Net of current law operations)						
End-of-Year Balance (Depletion)		-1707	-3998	-6628	-9625	-13001
EFFECT ON HI RESERVE FUND						
End-of-Year Balance		330	3998	6628	9625	13001
NET EFFECT ON HI BALANCES		-1377	-0	-0	-0	-0
Balance/Same Year's Outlays		-85.6%	-0.0%	-0.0%	-0.0%	-0.0%
MARGINAL EFFECT ON SMI TRUST FUND (Net of current law operations)						
End-of-Year Balance		1453	993	895	1295	1558
Balance/Same Year's Outlays		1346.3%	34.4%	23.4%	29.4%	30.8%
NET EFFECT ON HI/SMI BALANCES		76	992	895	1295	1558
Balance/Same Year's Outlays		4.4%	20.2%	14.9%	19.1%	20.5%
NEW CATASTROPHIC ACCOUNT AND NEW DRUG TRUST FUND						
EFFECT ON NEW CATASTROPHIC ACCOUNT						
End-of-Year Balance		76	992	895	1295	1558
Balance/Same Year's Outlays		4.4%	20.2%	14.9%	19.1%	20.5%
EFFECT ON NEW DRUG TRUST FUND						
End-of-Year Balance		0	242	1170	1552	1700
Balance/Same Year's Outlays			149.4%	99.0%	74.9%	57.6%
EFFECT ON NEW CATASTROPHIC AND DRUG ACCOUNTS COMBINED						
End-of-Year Balance		76	1235	2065	2847	3258
Balance/Same Year's Outlays		4.4%	24.4%	28.7%	32.2%	30.9%

SOURCE: Congressional Budget Office. 24-June-88

NOTE: Because premium rates would be fixed in law, with no provision for adjustment before 1994 to reflect changing circumstances, budget and trust fund effects will probably differ from those shown.

TABLE B-6. COMPARISON OF CONGRESSIONAL AND ADMINISTRATION ESTIMATES OF PUBLIC LAW 100-360
(By fiscal year, in millions of dollars)

	1989	1990	1991	1992	1993	1989-1993
CONGRESSIONAL ESTIMATES (Congressional Budget Office and Joint Committee on Taxation)						
Medicare Nondrug Provisions						
Benefits/Administrative Costs	1280	4096	5730	6575	7404	25085
Monthly Premiums	-1106	-1810	-2120	-2601	-2909	-10545
Supplemental Premiums	-315	-3857	-3644	-4346	-4799	-16960
Subtotal	-141	-1570	-34	-371	-304	-2420
Medicare Drug Provisions						
Benefits/Administrative Costs	32	132	927	1850	2732	5673
Monthly Premiums	0	-3	-582	-970	-1212	-2767
Supplemental Premiums	0	-390	-1278	-1318	-1712	-4699
Subtotal	32	-261	-933	-438	-192	-1793
Medicaid/Other Health Provisions	45	388	501	474	495	1903
Net Budget Effect	-64	-1444	-466	-335	-1	-2310
ADMINISTRATION ESTIMATES (Health Care Financing Administration and Treasury)						
Medicare Nondrug Provisions						
Benefits/Administrative Costs	1156	3750	5980	7267	8179	26332
Monthly Premiums	-1163	-1839	-2130	-2614	-2918	-10664
Supplemental Premiums	-388	-4191	-4364	-4854	-5143	-18940
Subtotal	-395	-2280	-514	-201	118	-3272
Medicare Drug Provisions /a/						
Benefits/Administrative Costs	0	97	1583	NA	NA	NA
Monthly Premiums	0	0	-593	-957	-1203	-2753
Supplemental Premiums	0	-266	-1580	-1454	-1775	-5075
Subtotal	0	-169	-590	NA	NA	NA
Medicaid/Other Health Provisions	125	495	605	770	1030	3025
Net Budget Effect	-270	-1954	-499	NA	NA	NA

SOURCES: Congressional Budget Office and Office of Management and Budget. 24-June-88

a. Administration estimates indicate drug trust fund would be exhausted in 1992.